



Client Name (last, first): _____
DOB: _____

Delaware Valley Children's Center

CLIENT/FAMILY AUTHORIZATION TO RELEASE PHI TO AN OUTSIDE AGENCY/PROVIDER

This authorization is based on Commonwealth regulations regarding release of protected health information under Pa P.L. 817, PA Code 55, Section 5100.33, and Federal Law (e.g. HIPAA). It is understood that the MINIMUM NECESSARY RULE will apply to both parties asking for or releasing protected health information. PHI beyond the Rule may require additional written justification from the requestor. Any information released MAY NOT BE RE RELEASED without authorization from the patient/guardian/parent under PA Code 55 {Section 5100.34(d)}.

CLIENT NAME ON RECORD _____ DOB _____

I x _____
AUTHORIZE PHILADELPHIA MENTAL HEALTH
CLINIC TO RELEASE THE SPECIFIED HEALTH
INFORMATION TO THE FOLLOWING PROVIDER:

I x _____
TO AUTHORIZE:

TO RELEASE THE FOLLOWING INFORMATION
TO: Philadelphia Mental Health Clinic

Information TO BE RELEASED from the record:

____ diagnosis ____ lab work
____ psychiatric assessment ____ attendance log
____ psychological assessment ____ psych. testing
____ summary of care ____ treatment plans

PURPOSE for which the information is to be used:

____ coordination of care between providers ____ QA chart audit
____ disability determination ____ BHRS Plan
____ legal proceeding ____ Medication History
____ educational planning ____ Other:

TIME FRAME OF COLLECTED INFORMATION TO BE RELEASED: FROM _____ TO _____

This authorization begins on _____ and expires on _____ (6 months) -OR- _____ (1 year)

I understand that I have the right to revoke this authorization in writing and no further information will be released other than that already released prior to my written notice of revocation.

x _____
initials

I understand that I have the right to review any of the above records (unless in the opinion of my treatment team it would be harmful for me to review them) prior to the records being released.

x _____
initials

I request that this information be sent to the fax numbers listed above; however, I am aware that there is a possibility, however remote, that an error in transmission could misdirect my information to the wrong party.

x _____
initials

x _____
Signature of client age 14 and above Date

Staff person obtaining authorization Date

x _____
Other Signature – Specify relationship to above: Date

If a VERBAL or TELEPHONE authorization *:

Person giving authorization _____
Client _____ or Relationship to Client _____

* Signature of 2 witnesses is required:

Witness _____

Witness _____

I revoke this authorization on _____.

Signed: _____

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Fax: (215) 598-9020